

FY17  
**FY17 RWHAP Part A & MAI Allocations Report**

<b>Section A: Identifying Information</b>	
San Francisco, California	
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Detailed instructions for completing and submitting your report can be downloaded from the HRSA Electronic Handbook: <https://grants.hrsa.gov/webexternal/Login.asp>

<b>Section B: Reporting Year Award Information</b>	
1. Part A Grant Award Amount	<b>\$15,042,799</b>
2. MAI Grant Request / Award Amount	<b>\$768,201</b>
<b>3. Total Part A Funds</b>	<b>\$15,811,000</b>

<b>Section C: Allocation Categories</b>	<b>1. Part A Award</b>		<b>2. MAI Award</b>		<b>3. Combined Total</b>	
	Amount	Percentage	Amount	Percentage	Amount	Percentage
<b>1. Core Medical Services Subtotal</b> <sup>1 (see CHECKLIST)</sup>	<b>\$8,224,419</b>	<b>61.70%</b>	<b>\$691,381</b>	<b>100.00%</b>	<b>\$8,915,800</b>	<b>63.59%</b>
a. Outpatient /Ambulatory Health Services	\$2,678,156	20.09%	\$497,634	71.98%	\$3,175,790	22.65%
b. AIDS Drug Assistance Program (ADAP) Treatments		0.00%		0.00%	\$0	0.00%
c. AIDS Pharmaceutical Assistance (local)		0.00%		0.00%	\$0	0.00%
d. Oral Health Care	\$806,269	6.05%		0.00%	\$806,269	5.75%
e. Early Intervention Services	\$31,461	0.24%		0.00%	\$31,461	0.22%
f. Health Insurance Premium & Cost Sharing Assistance	\$40,000	0.30%		0.00%	\$40,000	0.29%
g. Home Health Care	\$271,003	2.03%		0.00%	\$271,003	1.93%
h. Home and Community-based Health Services		0.00%		0.00%	\$0	0.00%
i. Hospice Services	\$784,687	5.89%		0.00%	\$784,687	5.60%
j. Mental Health Services	\$1,791,463	13.44%		0.00%	\$1,791,463	12.78%
k. Medical Nutrition Therapy		0.00%		0.00%	\$0	0.00%
l. Medical Case Management (incl. Treatment Adherence)	\$1,821,380	13.66%	\$193,747	28.02%	\$2,015,127	14.37%
m. Substance Abuse Services - outpatient		0.00%		0.00%	\$0	0.00%
<b>2. Support Services Subtotal</b>	<b>\$5,104,443</b>	<b>38.30%</b>	<b>\$0</b>	<b>0.00%</b>	<b>\$5,104,443</b>	<b>36.41%</b>
a. Case Management (non-Medical)	\$1,949,845	14.63%		0.00%	\$1,949,845	13.91%
b. Child Care Services		0.00%		0.00%	\$0	0.00%
c. Emergency Financial Assistance	\$1,102,597	8.27%		0.00%	\$1,102,597	7.86%
d. Food Bank/Home-Delivered Meals	\$120,000	0.90%		0.00%	\$120,000	0.86%
e. Health Education/Risk Reduction		0.00%		0.00%	\$0	0.00%
f. Housing Services	\$890,732	6.68%		0.00%	\$890,732	6.35%
g. Legal Services	\$284,620	2.14%		0.00%	\$284,620	2.03%
h. Linguistics Services		0.00%		0.00%	\$0	0.00%
i. Medical Transportation Services	\$14,000	0.11%		0.00%	\$14,000	0.10%
j. Outreach Services	\$267,677	2.01%		0.00%	\$267,677	1.91%
k. Psychosocial Support Services	\$474,972	3.56%		0.00%	\$474,972	3.39%
l. Referral for Health Care/Supportive Services		0.00%		0.00%	\$0	0.00%
m. Rehabilitation Services		0.00%		0.00%	\$0	0.00%
n. Respite Care		0.00%		0.00%	\$0	0.00%
o. Substance Abuse Services - residential		0.00%		0.00%	\$0	0.00%
p. Treatment Adherence Counseling		0.00%		0.00%	\$0	0.00%
<b>3. Total Service Allocations</b>	<b>\$13,328,862</b>	<b>100.00%</b>	<b>\$691,381</b>	<b>100.00%</b>	<b>\$14,020,243</b>	<b>100.00%</b>
<b>4. Non-services Subtotal</b>	<b>\$1,713,937</b>	<b>11.39%</b>	<b>\$76,820</b>	<b>10.00%</b>	<b>\$1,790,757</b>	<b>11.33%</b>
a. Clinical Quality Management <sup>2 (see CHECKLIST)</sup>	\$350,000	2.33%		0.00%	\$350,000	2.21%
b. Grantee Administration <sup>3 (see CHECKLIST)</sup>	\$1,363,937	9.07%	\$76,820	10.00%	\$1,440,757	9.11%
<b>5. Total Allocations (Service + Non-service)</b> <sup>4 (see CHECKLIST)</sup>	<b>\$15,042,799</b>	<b>100.00%</b>	<b>\$768,201</b>	<b>100.00%</b>	<b>\$15,811,000</b>	<b>100.00%</b>

**FOR OFFICE USE ONLY:**

Grantee received waiver for 75% core medical services requirement.

**PUBLIC BURDEN STATEMENT:** An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB number. The OMB control number for this project is 0915-0318. Public reporting burden for this collection of information is estimated to be 1.5 hours per response. These estimates include the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments to HRSA Reports Clearance Officer, Health Resources and Services Administration, Room 10-33, 5600 Fishers Lane, Rockville, MD. 20857.

## FY 2017 RYAN WHITE PART A PROJECT ABSTRACT

**Project Title:** Enhancing Outcomes the Continuum of Care: San Francisco EMA FY 2017 Ryan White Part A Competing Continuation Application

**Applicant Name:** San Francisco HIV Health Services

**Address:** 25 Van Ness Avenue, Suite 500, San Francisco, CA, 94102

**Project Director:** Bill Blum, Director, HIV Health Services

**Contact Numbers:** Office: (415) 554-9105 / Fax: (415) 431-7547

**E-Mail Address:** bill.blum@sfdph.org / **Web Address:** www.sfhivcare.com

**Total Funds Requested in Application:** \$17,495,002

**General TGA Demographics:** The 2010 US Census population of the San Francisco EMA is **1,776,095**, including a population of **252,409** in Marin County, **805,235** in San Francisco County, and **718,451** in San Mateo County, with widely varying population densities among the three regions. **Over half** of the EMA's residents are people of color, including large Asian/Pacific Islander (**26.7%**), Latino (**19.3%**), and African American (**4.3%**) populations. **Over 42%** of EMA residents speak a language other than English at home.

**HIV Overview:** As of December 31, 2015, a total of **16,554** persons were living with HIV in the San Francisco EMA for an EMA-wide HIV infection incidence of **932.0** cases per 100,000 persons. The epidemic disproportionately impacts men who have sex with men, who make up **85.4%** of all PLWH in the region. Fully **57.1%** of all PLWH in the EMA are age 50 and older, most of whom are long-term survivors.

**Geography in Relation to Care:** The San Francisco EMA is a diverse region encompassing Marin County in the north, San Francisco County in the center, and San Mateo County in the south. San Francisco County covers an area of only **47** square miles, making it geographically the smallest county in California and the sixth smallest in the US. The density of San Francisco is **17,170** persons per square mile - one of the highest population densities of any city in the U.S. In both Marin and San Mateo Counties, cases and services are focused around the major cities bordering the north-south-running Highway 101.

**Continuum of Care:** Throughout the EMA, the emphasis on **high-quality, client-centered primary medical care services** is at the heart of the continuum of care, with medical case management providing individualized coordination and entry points to a range of medical and social services. In addition to major hospitals in the EMA, there are **seven** public clinics and **six** community clinics in San Francisco County, **two** public clinics in San Mateo County, and **one** public clinic in Marin County providing HIV/AIDS primary care. San Francisco's **seven Centers of Excellence** form an innovative network of HIV providers designed to involve and retain complex, hard-to-reach, and multiply diagnosed populations in care.

**Ryan White History:** San Francisco was one of the 16 original Title I EMAs funded by the Ryan White CARE Act in **1991** and first began receiving MAI funding in **1999**.

**Changes Resulting from ACA Implementation:** The most dramatic change in relation to ACA implementation has been a **31.8%** reduction in Part A expenditures for Outpatient Ambulatory Health Services from FY 2014 to FY 2016, from **\$4,252,006** expended for primary medical care in FY 2014 to a projected **2,901,207** to be expended in FY 2016.

**Continuum-Related Successes and Challenges:** The San Francisco EMA has achieved an unprecedented level of success in reducing the number of persons with HIV in the EMA who are unaware of their serostatus, currently estimated at **6.4%**. At the same time, the EMA's viral load suppression rate of **71%** far surpasses the national average of **25%**.

**ENHANCING OUTCOMES ALONG THE HIV CONTINUUM OF CARE:  
SAN FRANCISCO EMA FY 2017 RYAN WHITE PART A  
COMPETING CONTINUATION APPLICATION NARRATIVE**

**INTRODUCTION**

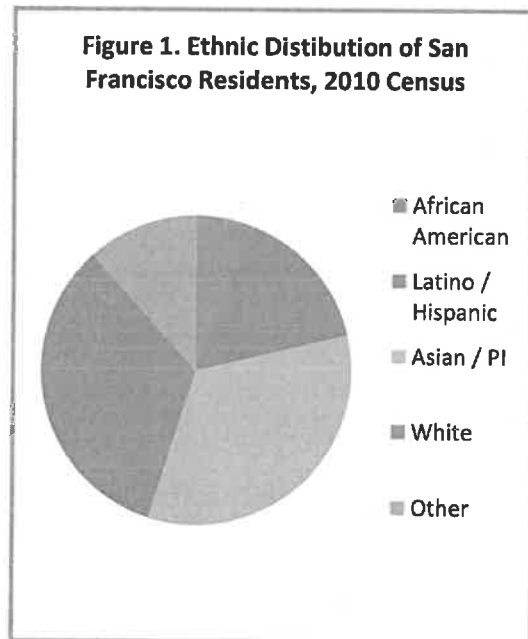
The San Francisco Eligible Metropolitan Area (EMA) requests a total **\$17,495,002** in Ryan White Part A Formula and Supplemental funding for our region to continue to meet the ongoing local crisis of HIV infection in an effective and strategic manner, which is fully coordinated within the overarching HIV Continuum of Care. Requested funds will ensure a seamless, comprehensive, and culturally competent system of care focused on the complementary goals of reducing inequities and disparities in HIV care access and outcomes and ensuring parity and equal access to primary medical care and support services for all residents in the region. The FY 2017 Part A Service Plan described in our application strikes a balance between providing an integrated range of intensive health and supportive services for complex, severe need, and multiply diagnosed populations, and expanding and nurturing the self-management and personal empowerment of persons living with HIV. The Plan also highlights expanded integration with HIV outreach, testing, linkage, and care retention services and incorporates the perspectives and input of a broad range of consumers, providers, and planners from across the region, as well as findings of key data sources described below. The FY 2017 Part A application presents an effective strategy to both preserve and advance a tradition of HIV service excellence in the San Francisco EMA.

**NEEDS ASSESSMENT**

**A. Epidemiologic Overview**

**A.1) Overview of the Geographic Region:**

Located along the western edge of the San Francisco Bay in Northern California, the San Francisco Eligible Metropolitan Area (EMA) is a unique, diverse, and highly complex region. Encompassing three contiguous counties - **Marin County** to the north, **San Francisco County** in the center and **San Mateo County** to the south - the EMA has a total land area of **1,016** square miles, an area roughly the size of Rhode Island. In geographic terms, the EMA is very narrow, stretching more than 75 miles from its northern to southern end, but less than 20 miles at its widest point from east to west. This complicates transportation and service access in the region, especially for those in Marin and San Mateo Counties. In San Mateo County, a mountain range marking the western boundary of the San Andreas Fault bisects the



region from north to south, creates challenges for those attempting to move between the county's eastern and western sides. The San Francisco (SF) EMA is also unusual because of the dramatic difference in the size of its member counties. While Marin and San Mateo Counties have a land area of **520** and **449** square miles, respectively, San Francisco County has a land area of only **46.7** square miles, making it **by far the smallest county in California** geographically, and the **sixth smallest county in the US** in terms of land area. San Francisco is also one of only three major cities in the US (the others are Denver and Washington, DC) in which the city's borders are identical to those of the county in which it is located. The unification of city and county governments under a single mayor and Board of Supervisors allows for a streamlined service planning and delivery process.

According to 2010 US Census data, the total population of the San Francisco EMA is **1,776,095**.<sup>1</sup> This includes a population of **252,409** in Marin County, **805,235** in San Francisco County, and **718,451** in San Mateo County, with widely varying population densities within the three regions. While the density of Marin County is **485** persons per square mile, the density of San Francisco County is **17,170 persons per square mile** - the highest population density of any county in the nation outside of New York City. While San Mateo County lies between these two extremes, its density of **1,602** persons per square mile is still more than ten times lower than its neighbor county to the north. These differences necessitate varying approaches to HIV care in the EMA.

The geographic diversity of the San Francisco EMA mirrors the diversity of the people who call the area home. Over **half** of the EMA's residents (**53.3%**) are persons of color, including Asian/Pacific Islanders (**26.7%**), Latinos (**19.3%**), and African Americans (**4.3%**). In San Francisco, persons of color make up **58.1%** of the total population, with Asian residents alone making up over **one-third** (**33%**) of the City's total population (see **Figure 1**). The nation's largest population of Chinese Americans lives in the City of San Francisco and is joined by a diverse group of Asian immigrants, including large numbers of Japanese, Vietnamese, Laotian, and Cambodian residents. A large number of Latino immigrants also reside in the EMA, including natives of Mexico, Guatemala, El Salvador, and Nicaragua. EMA-wide, **31.6%** of residents were born outside the US and **41.7%** of residents speak a language other than English at home, with over **100** separate Asian languages and dialects spoken in SF. Only **half** of the high school students in the City of San Francisco were born in the United States, and almost **one-quarter** have been in the country six years or less. A total of over **20,000** new immigrants join the EMA's population each year, in addition to at least **75,000** permanent and semi-permanent undocumented residents.

## **A.2) Profile of the Local HIV Epidemic**

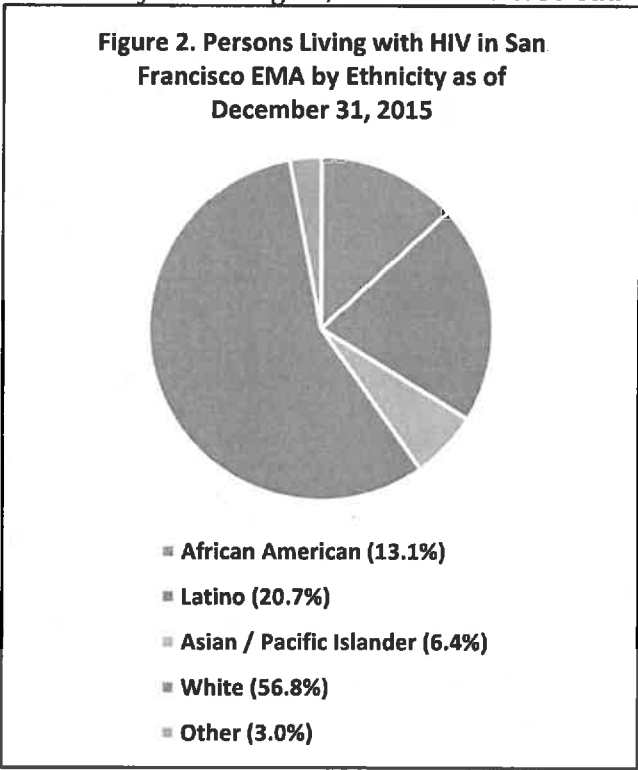
### **HIV Demographic Table - Please see Attachment 3**

**A.2.a) HIV Demographic Data:** More than a quarter century into the HIV epidemic, the three counties of the San Francisco region continue to be devastated by HIV – an ongoing crisis that has exacted an enormous human and financial toll on our region. According to the State of California, as of June 30, 2014, a total of **40,819** cumulative cases of HIV had been diagnosed in the region, representing nearly **one in five** HIV cases ever diagnosed in the state of California (n=**220,543**).<sup>2</sup> Over **22,979** persons have died as a result of HIV infection in the region. As of December 31, 2015, a total of **16,554** persons were living with HIV in the region's three counties, for a region-wide HIV infection incidence of **932.0** cases

per 100,000 persons, meaning that nearly **1 in every 100 residents of the San Francisco region is now living with HIV.**

At the epicenter of this continuing crisis lies the City and County of San Francisco, the city hardest-hit during the initial years of the AIDS epidemic. Today, the City of San Francisco continues to have the nation's highest per capita prevalence of cumulative AIDS cases,<sup>3</sup> and HIV remains the leading cause of death in the city among all age groups, as it has been for nearly two decades.<sup>4</sup> As of the end of 2015, at least **13,971** San Franciscans were living with HIV infection, representing **84.4%** of all persons living with HIV in the three-county region, for a staggering citywide prevalence of **1,735.0 cases of HIV per 100,000**. A total of at least **288** new cases of HIV infection were diagnosed in San Francisco in calendar year 2015 alone,

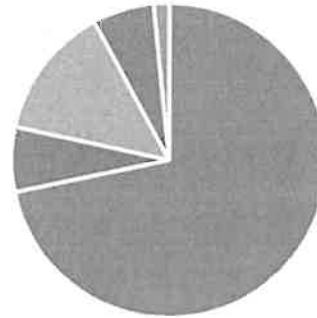
**Race / Ethnicity:** Reflecting the ethnic diversity of our region, the local HIV caseload is distributed among a wide range of ethnic groups. The majority of persons living with HIV (PLWH) are white (**56.8%**), while **13.1%** of cases are among African Americans; **20.7%** are among Latinos; and **6.4%** are among Asian / Pacific Islanders (see **Figure 2**). A total of **7,150** persons of color were living with HIV infection in the three-county region as of December 31, 2014, representing **43.2%** of all persons living with HIV. African Americans are significantly over-represented in terms of HIV infection, making up **13.1%** of all persons living with HIV while comprising only **4.3%** of the area's population. This disproportion is even greater among **women** with HIV, a group in which African American women make up **39%** of all PLWH while comprising **4.1%** of the region's total female population. Additionally, among the region's hard-hit transgender population, persons of color make up **79.6%** of all PLWH, including a population that is **36.3%** African American, **30.2%** Latino, and **9.1%** Asian / Pacific Islander.



**Transmission Categories:** The most important distinguishing characteristic of the HIV epidemic in the San Francisco region is that HIV remains primarily a disease of men who have sex with men (MSM). In other regions of the US, the proportionate impact of HIV on MSM has declined over time as populations such as women, injection drug users, and heterosexual men have been increasingly affected by the epidemic. While these groups have been impacted in our region as well, their representation as a proportion of total PLWH has remained relatively low. Through December 31, 2015, fully **85.4%** of persons living with HIV in our region were MSM (**14,140**), including **11,865** men infected with HIV

through MSM contact only (71.7% of all PLWH) and 2,275 MSM who also injected drugs (13.7% of all PLWH) (see Figure 3). This represents an increase from the end of 2008, when MSM made up 82.3% of all PLWH. By comparison, only 37.9% of PLWH in New York City as of December 31, 2013 were listed as infected through MSM contact.<sup>5</sup> Factors underlying this difference include the high proportion of gay and bisexual men living in the region; the large number of local long-term MSM HIV survivors; growing rates of STD infection among MSM; and relatively high local drug use rates. Other significant local transmission categories include heterosexual persons who inject drugs (PWID) (6.6% of PLWH) and non-PIWD heterosexuals (4.5%).

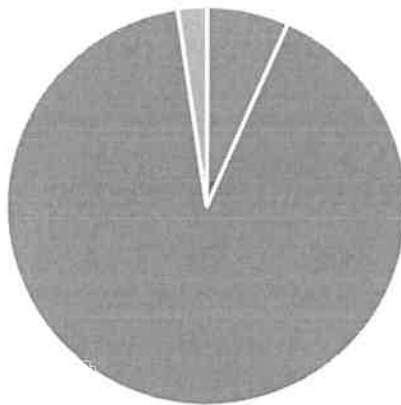
**Figure 3. Persons Living with HIV in San Francisco EMA by Transmission Category as of December 31, 2015**



- MSM (71.7%)
- IDU (6.7%)
- MSM / IDU (13.7%)
- Non-IDU Heterosexuals (6.3%)
- Other / Unknown (1.6%)

**Gender:** Reflecting the high prevalence of HIV among men who have sex with men, the vast majority of those living with HIV in the San Francisco region (91.0%) are men (see Figure 4). Only 6.6% of all PLWH in the region are women, over 70% of whom are women of color. Among African Americans living with HIV, 15.2% are women. The three-county San Francisco region has historically contained what is by far the lowest percentage of women, infants, children, and youth (WICY) living with HIV of any HIV region or

**Figure 4. Persons Living with HIV in San Francisco EMA by Gender as of December 31, 2015**



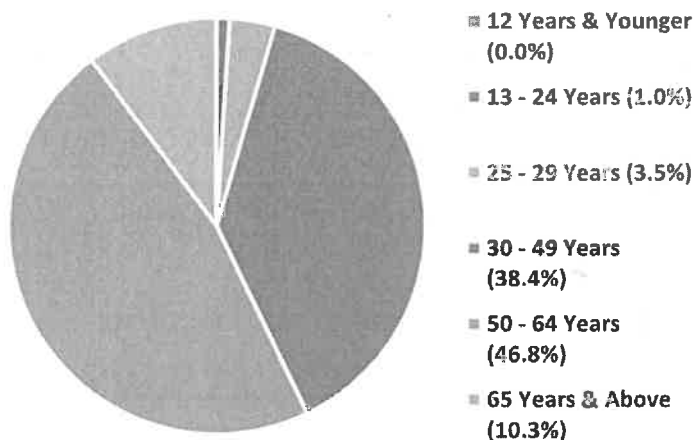
- Female (6.6%)
- Male (91.0%)
- Transgender (2.4%)

jurisdiction in the nation. Because of their high representation within the San Francisco population, transgender persons also make up a significant percentage of PLWH, with at least 401 transgender individuals - the vast majority of them male-to-female - living with HIV as of December 31, 2015, representing 2.4% of the region's PLWH caseload.

**Current Age:** The majority of persons living with HIV in the San Francisco region are age 50 and above. This is attributable to the long history of the epidemic in our region - resulting in a large proportion of long-term survivors - as well as to the region's hard-fought success in bringing persons with HIV into care and

maintaining their health of time. As of December 31, 2015, well over **half** of all persons living with HIV in the region (**57.1%**) are age 50 or older, including **7,748** PLWH between the ages of 50 and 64 and **1,704** PLWH age 65 and higher (see **Figure 5**). Between December 2009 and December 2015 alone, the number of persons 50 and over living with HIV increased by nearly **40%** within the region (from **41.2%**) while the number of PLWH 65 and older increased by **41.1% over the last 12 months alone**. This growing aging population creates significant challenges for the local HIV service system,

**Figure 5. Persons Living with HIV in San Francisco EMA by Current Age, December 31, 2014**



including the need to coordinate and integrate HIV and geriatric care and to plan for long-term impacts of HIV drug therapies. Persons between the ages of 30 and 49 make up **38.4%** of all PLWH in the region (n=6,351) while young adults ages 25 - 29 make up **3.5%** (n=575). A total of **172** young people between the ages of 13 and 24 are estimated to be living with HIV in the region, constituting **1.0%** of the PLWH population. However, young people ages 13-24 make up **15%** of all new HIV cases identified in calendar year 2015, pointing to a growing HIV incidence within this population. Only **4** children age 12 and under are living with HIV in the region, and **no** new AIDS cases were diagnosed among this group between January 1, 2010 and December 31, 2015.

**A.2.b) Socioeconomic Data:**

**Poverty:** The problem of poverty presents a daunting challenge to the HIV care system. According to the 2010 Census, the average percentage of persons living at or below federal poverty level stands at **9.2%** for the entire San Francisco region. Using this data, SF DPH projects that at least **490,201** individuals in the San Francisco region are living at or below 300% of Federal Poverty Level, which translates to **27.6%** of the overall region population lacking resources to cover all but the most basic expenses. **However, because of the high cost of living in the San Francisco Bay Area, persons at 300% of poverty or below have a much more difficult time surviving in our area than those living at these income levels in other parts of the U.S.** Analyzing data from the San Francisco AIDS Regional Information and Evaluation System (ARIES), the SF region's client-level data system, it is estimated that at least **60.1%** of all persons living with HIV in the San Francisco region (n=9,941) are living at or below 300% of the 2016 Federal Poverty Level (FPL) including persons in impoverished households, while **95%** of Ryan White-funded clients live at or below 300% of poverty.<sup>6</sup> ARIES data also reveals that **58.0%** of active Ryan White clients in the San Francisco region are currently living at or below 100% of FPL while another **26.7%** are living between 101% and 200% of FPL. HIV-infected

persons in poverty clearly have a higher need for subsidized medical and supportive services, accounting for at least **\$249 million** in Part A and non-Part A HIV-related expenditures in the San Francisco region each year<sup>7</sup>.

**Housing and Homelessness:** Housing is an indispensable to ensure good health outcomes for persons with HIV. Without adequate, stable housing it is highly challenging for individuals to access primary care; maintain combination therapy; and preserve overall health and wellness. These issues are more critical for persons with co-morbidities such as substance addiction and/or mental illness, since maintaining sobriety and medication adherence is much more difficult without stable housing. Homelessness is also a critical risk factor for HIV, with one study reporting HIV risk factors among **69%** of homeless persons.<sup>8</sup>

Because of the prohibitively high cost of housing in the San Francisco region and the shortage of affordable rental units, the problem of homelessness has reached crisis proportions, creating formidable challenges for organizations seeking to serve HIV-infected populations. According to the National Low Income Housing Coalition's *Out of Reach 2016* report, Marin, San Francisco, and San Mateo Counties – the three counties that make up the San Francisco region – **are tied with one another as the three least affordable**

**counties in the nation** in terms of the minimum hourly wage needed to rent an average two-bedroom apartment, which currently stands at **\$44.02 per hour** (see Figure 6).<sup>9</sup> Meanwhile, in 2015, the City of San Francisco has the **highest HUD-established Fair Market Rental rate in the nation** at **\$2,801** per month for a 2-bedroom apartment, which represents the amount needed to “pay the gross rent of privately owned, decent, and safe rental housing of a modest nature”.<sup>10</sup> An analysis of 2015-2016 ARIES data revealed that only **two-thirds** Ryan White clients were stably housed during the year (**65.9%**), with **21.9%** living in temporary housing and **5.3%** living in unstable housing.

**Insurance Coverage:** The advent of health care reform through the Affordable Care Act (ACA) has resulted in significant, positive change in regard to the number and proportion of low-income persons with HIV in our region who benefit from affordable and more accessible health insurance coverage. According to the UCLA Center for Health Policy Research, the number of uninsured Californians had fallen by as much as **40%** as of February 2015 as a result of ACA implementation.<sup>11</sup> Nevertheless, significant insurance gaps continue to remain in our region. Analysis of local ARIES data revealed that fully **29.0%** of all persons enrolled in Ryan White services in the three-county region as of 2015 remained uninsured, including persons without Medicaid or Medicare.

**Figure 6.  
Top 9 Least Affordable Counties in the U.S.  
in Terms of Housing Costs, 2016**

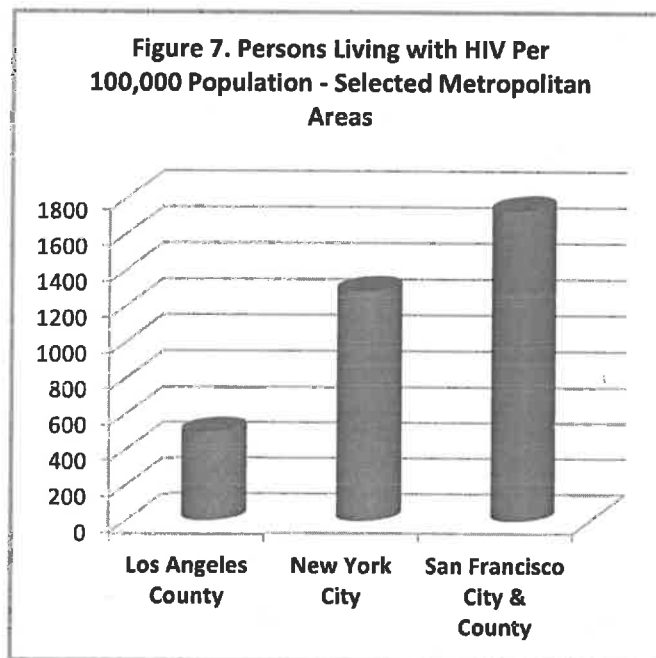
County	Hourly Wage to Rent a 2-Bdrm. Apt. at HUD Fair Market Rents
San Francisco County, CA	\$ 44.02
Marin County, CA	\$ 44.02
San Mateo County, CA	\$ 44.02
Alameda County, CA	\$ 40.44
Contra Costa County, CA	\$ 40.44
Santa Clara County, CA	\$ 38.35
Honolulu County, HI	\$ 38.17
Orange County, CA	\$ 32.15
Pitkin County, CO	\$ 31.96



Additionally, significant **disparities** exist in regard to type of health insurance coverage among newly diagnosed persons with HIV. While the percentage of persons in San Francisco who had insurance at the time of HIV diagnosis was relatively comparable across ethnic groups (67% of whites; 66% of African Americans; 60% of Latinos; and 59% of other ethnic groups) the **type** of insurance varied greatly among populations. For example, while 46.9% of whites had private insurance at the time of HIV diagnosis, only 16.0% of African Americans and 35.6% of Latinos had private insurance. Conversely, while 11.1% of whites and 13.0% of Latinos had Medicaid coverage at the time of diagnosis, fully 34.4% of African Americans were covered by Medicaid at the time of initial HIV diagnosis. Even more ominous is the fact that nearly 35% of whites and African Americans and 40% of Latinos and other populations were **uninsured** at the time of diagnosis, despite extensive regional efforts to enroll low-income individuals in one of the region's many medical insurance programs tailored to these populations.

The issue of persons **losing their private disability insurance** is growing in importance as the population of PLWH who are 50 years or older increases and are more likely to rely on private disability insurance than their younger counterparts. In October of 2014, the San Francisco Board of Supervisors, Budget and Legislative Analyst Office released a Policy Analysis Report on PLWH who age off Long Term Disability Insurance. The report reviewed data from several sources to estimate the number of PLWH who have private disability insurance and will reach retirement age and Social Security eligibility in the next 15 years. The report found that over 1,200 PLWH over 50 years old rely on private disability insurance, which terminates at age 65. The overall effect of the drop in income that will occur as people lose their private disability insurance is difficult to predict conclusively. However, evidence does suggest that for many PLWH, the lost income will make it impossible to afford San Francisco's current median rent.

**A.3) Burden of HIV in the Service Area:** It is important to note that the City of San Francisco continues to have the **largest per capita concentration of persons living with HIV of any metropolitan region in the United States**. As noted above, as of the end of 2015, a total of 13,971 San Franciscans were living with diagnosed HIV, representing 84.4% of all persons living with HIV in the EMA. **This means that 1 in every 58 San Francisco residents is now living with HIV disease - an astonishing concentration of HIV infection in a city with a population of just over 800,000.** The incidence of 1,735.0 persons living with HIV per 100,000 in San Francisco County is **over three times** that of Los Angeles County (498.1 per 100,000) and **35% higher** than New York City (1,285.5 per 100,000) (see Figure 7).<sup>12</sup>



**A.4) Indicators of HIV Infection Risk:** Please note that a thorough description of local HIV infection risk indicators is provided in **Section C.5** below, specifically in the section on **Co-Morbidities**. This includes a description of Hepatitis C risk; STI and tuberculosis rates; rates of mental illness and substance abuse; and the impact of incarceration on the service region.

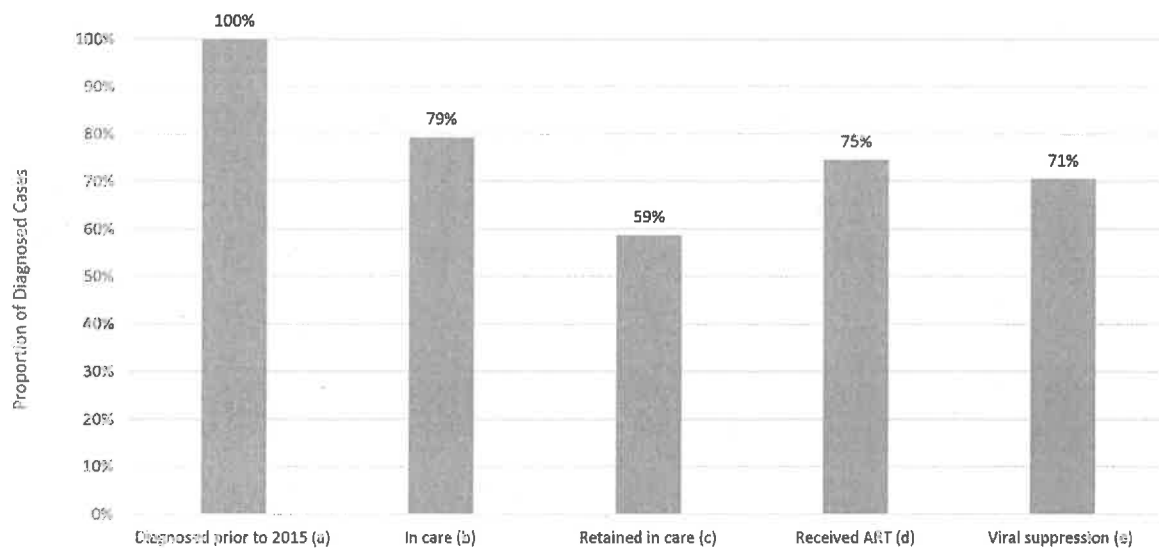
**Trends in New HIV Infections:** New HIV infection data for the City of San Francisco for the years 2006 to 2014 continue to show consistent and relatively steady decreases in the number of new infections reported across all ethnicities. Between 2006 and 2014, the number of newly identified HIV infections among white men declined by **51.1%**, from **278** to **136** new cases, while the number of newly identified cases among African American men declined by **56.0%**, from **75** in 2006 to **33** in 2014. New HIV cases among Latino men also dropped over the same period, from **113** new cases in 2006 to **82** in 2014, a decline of **27.4%**. However, as a proportion of their representation in the community as a whole, African American and Latino men still have significantly higher rates of infection per 100,000 among members of their ethnic group than white men. While the rate of new HIV diagnoses in 2014 among white San Francisco males was **69** per 100,000, the rate was **107** per 100,000 for Latino men and **127** per 100,000 for African American men. Meanwhile, new HIV diagnoses among women continue to drop dramatically, most notably with a decline in new HIV diagnoses among African American women from **47** new diagnoses in 2006 to **9** new diagnoses in 2014. The rate of new HIV infections per 100,000 among women in San Francisco is **4** for white women, **6** for Latina women, and **9** for African American women.

#### **B) FY 2017 HIV Care Continuum**

**B.1) Care Continuum Graph** - See chart on following page

**B.2) Disparities in Regard to the HIV Care Continuum:** During calendar year 2015, **79%** of PLWH in the San Francisco EMA were categorized as being in care (defined as at least 1 medical visit during the calendar year); **59%** were retained in care (defined as at least 2 medical visits at least 90 days apart during the calendar year); **75%** received ART; and **71%** achieved viral suppression. However, despite these successes, some significant disparities remain in terms of care continuum outcomes. A detailed analysis of 2014 HIV care continuum data conducted as part of this year's integrated HIV planning process found, for example, that a lower proportion of **men** were retained in care three to nine months after initial linkage to care (**72%**) (see **Figure 8**). **African Americans** had a lower proportion of linkage to care both one month and three months after diagnosis (**67%** and **81%**, respectively); retention in care (**64%**); and viral suppression 12 months after diagnosis (**53%**). While a greater proportion of newly diagnosed persons who were homeless were linked to care within three months of diagnosis (**94%** compared to **90%** among those who were housed), only **53%** achieved viral suppression within 12 months of diagnosis compared to **77%** among those who were housed. This suggests that more needs to be done among the homeless after initial linkage to care to ensure they initiate and adhere to ART.

### San Francisco EMA HIV Continuum of Care Among Prevalent Cases, 2015 (n=16,218)



- (a) Includes persons diagnosed before 2015 who were alive and residing in EMA at end of 2015.
- (b)  $\geq 1$  CD4, VL or genotype tests during 2015.
- (c)  $\geq 2$  CD4, VL and/or genotype tests at least 3 months apart during 2015.
- (d) Based on chart reviews of a representative subset of SF patients in care.
- (e) Last VL during 2015  $\leq 200$  copies/mL.

**Figure 8. Care Indicators Among Persons Newly Diagnosed with HIV in 2014 by Demographic and Risk Characteristics, San Francisco**

Characteristics	Number of diagnoses <sup>1</sup>	% Linked to care within 1 month of diagnosis <sup>2</sup>	% Linked to care within 3 months of diagnosis <sup>2</sup>	% Retained in care 3-9 months after linkage <sup>2</sup>	% Virally suppressed within 12 months of diagnosis <sup>2</sup>
<b>Total</b>	<b>334</b>	<b>84%</b>	<b>91%</b>	<b>73%</b>	<b>75%</b>
<b>Gender</b>					
Male	313	85%	90%	72%	74%
Female	14	64%	93%	93%	79%
Transfemale	7	71%	100%	86%	71%
<b>Race/Ethnicity</b>					
White	143	87%	94%	76%	76%
African American	36	67%	81%	64%	53%
Latino	96	81%	88%	71%	78%
A/PI	42	88%	93%	76%	86%
Other/Unknown	17	94%	94%	65%	65%
<b>Age at Diagnosis</b>					
13-24	37	76%	84%	65%	73%
25-29	54	93%	98%	81%	81%
30-39	101	75%	85%	63%	67%
40-49	81	89%	91%	79%	78%
50+	61	87%	97%	77%	77%
<b>Transmission Category</b>					
MSM	253	84%	91%	75%	78%
PWID	19	79%	95%	63%	63%
MSM-PWID	37	86%	89%	65%	57%
Heterosexual	11	82%	100%	82%	91%
Other/Unidentified	14	79%	86%	57%	57%
<b>Housing Status</b>					
Housed	298	83%	90%	73%	77%
Homeless	36	89%	94%	69%	53%

1 Includes persons diagnosed in 2014 based on a confirmed HIV test and does not take into account patient self-report of HIV infection.

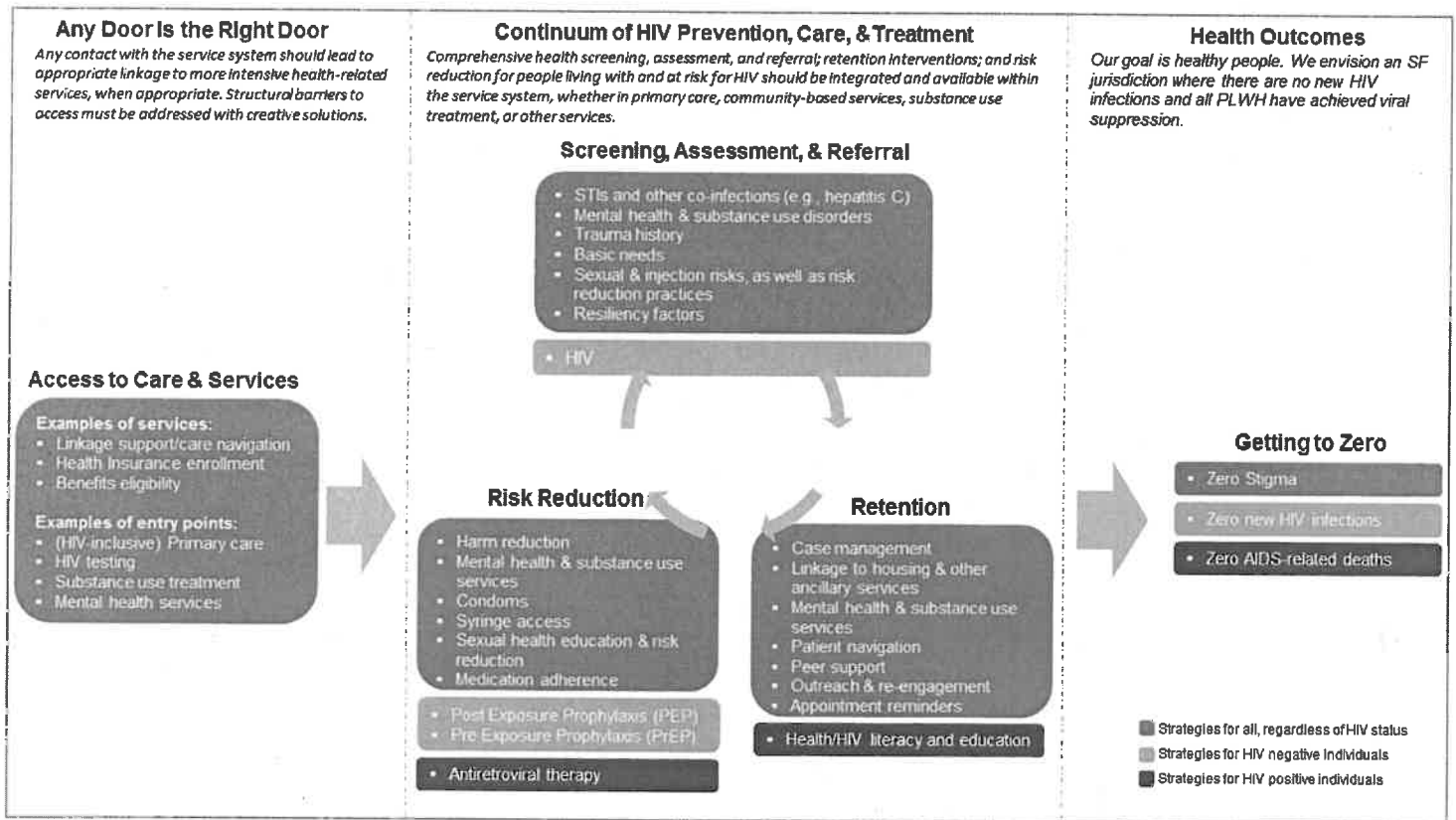
2 Percent of total diagnoses.

**B.2.a) Utilization of the HIV Care Continuum:** The San Francisco EMA's HIV prevention and care continuum strategy reflects a forward-thinking understanding of how to best meet the needs of people living with and at risk for HIV (PLWARH). The framework outlined in **Figure 9** on the following page builds from the concept of treatment as prevention to addressing HIV as a **holistic health issue**. The model illustrates how prevention, care, and treatment are **inextricably intertwined**, and prioritizes the needs of people **regardless of HIV status**. Given that with advances in treatment and prognosis the needs of PLWH and those at risk are no longer as different as they once were, there are increased opportunities for affected communities to come together around a common vision and set of priorities, including ensuring access to health care and other services; providing a continuum of HIV prevention, care and treatment services using a holistic approach; and ultimately, as a result, **“getting to zero” - meaning zero new infections, zero AIDS-related deaths, and zero stigma – may be within our reach for the first time in the history of the epidemic.**






**B.2.b) How the HIV Care Continuum is Evaluated in Our Region:** The newly merged San Francisco HIV Community Planning Council hosts regular presentations and updates on the local continuum by staff of the San Francisco Department of Public Health and considers disparities in continuum outcomes in regard to sub-populations when making prioritization and allocation decisions and planning prevention strategies and services. The Department itself utilizes continuum outcomes as a strategy to assess the effectiveness of the local prevention and care system in meeting existing and emerging prevention and care needs, and to plan enhanced services and programs to better address shortfalls in continuum targets.

**B.2.c) How the Care Continuum is Utilized in Planning and Prioritization:** The continuum of care framework embodies an approach to comprehensive care which has begun to have an important impact on HIV prevention and service planning in the San Francisco region. The Continuum of Care provides invaluable information regarding the future, merged direction of HIV prevention and care and reinforces an already understood need for providers to better manage, enter, track, and coordinate data, and to begin to build expanded bridges of information-sharing between public and private providers. **Figure 10** below provides a schematic view of the EMA's vision of developing goals and achieving objectives of an integrated continuum of care. It is important to note that service integration may offer some solutions to challenges that HIV prevention has long faced. Historically, HIV prevention has been asked to fund services for populations at high risk for a variety of health issues, even though risk for HIV may be low. For example, it is not uncommon to hear that services for non-MSM populations, such as HIV-negative women and non-MSM youth, are insufficient. Integration offers opportunities to fund services appropriately, while also meeting the need (e.g., integrating HIV prevention messages into homeless services at low or no cost). The HIV prevention and sexual health needs in Bayview/Hunters Point, which is home to many HIV care and treatment services but few HIV prevention services, can potentially be addressed by leveraging non-HIV-related efforts and broader health initiatives (e.g., SFDPH's Black/African American Health Initiative). Finally, in the process of “getting to zero,” the target population will be harder and harder to reach. Integrated services where HIV is not the focus might attract clients that we haven't been able to reach in any other way.

**Figure 9: San Francisco Jurisdiction Holistic Health Framework for HIV Prevention and Care**



**Figure 10. Sample San Francisco EMA Integrated HIV Prevention & Care Goals**

Goals	Indicators	Data	Overall Trend
Reduce new HIV infections	<i>New diagnoses</i>	2011: 510 2012: 495 2013: 418 <i>SF, San Mateo, and Marin. Source: County HIV surveillance data.</i>	
	<i>Estimated % of MSM in SF who are unaware of their HIV-positive status</i>	2005: 23% 2008: 17% 2011: 6% <i>SF only. Source: NHBS.</i>	
Increase access to care and improve health outcomes for PLWH	<i>Linkage to care</i>	2011: 84% 2012: 86% 2013: 89% <i>SF and Marin only. SF data is linkage to care within 3 months. Marin data is linkage to care within 6 months. Source: County HIV surveillance data.</i>	
	<i>Late diagnosis</i>	2010: 26% 2011: 24% 2012: 21% <i>SF only. Data represents the proportion of new HIV diagnoses that developed AIDS within 3 months of diagnosis. Source: County HIV surveillance data.</i>	
	<i>Viral suppression</i>	2010: 56% 2011: 58% 2012: 68% <i>SF only. Data represents the proportion virally suppressed within 12 months of diagnosis. Source: County HIV surveillance data.</i>	

**C. Demonstrated Need**

**C.1) Early Identification of Individuals with HIV/AIDS (EIIHA)**

**“I love the San Francisco model. If it keeps doing what it is doing, I have a strong feeling that they will be successful at ending the epidemic as we know it. Not every last case - we’ll never get there - but the overall epidemic. And then there’s no excuse for everyone not doing it.”**

**- Dr. Anthony S. Fauci,  
Director, National Institute of Allergy and Infectious Diseases  
New York Times, October 5, 2015<sup>13</sup>**

**FY 2017 EIIHA Plan**

**C.1.a) Process for Linking People Identified in EIIHA Data to Prevention and Care Services, Including Community Partners and Complementary Resources: San**

San Francisco brought about a major enhancement of its HIV testing services matrix in FY 2015 by implementing the **Linkage Integration Navigation Comprehensive Services (LINCS) program**, a highly effective program designed to increase the number of HIV-infected individuals who are effectively linked to and anchored in care. The LINCS Team provides a comprehensive range of services based on individual client needs and circumstances, incorporating linkage to HIV medical care, social services, partner services, and retention services under a single umbrella. LINCS employs an integrated team of **15** full-time staff. **Eight** staff provide HIV and syphilis partner services and linkage to care to newly diagnosed patients, and **7** staff provide HIV care navigation to patients who are identified as out of care by healthcare providers or through HIV surveillance data. Of note, 6 of these navigation staff are short-term grant-funded through the MAC AIDS Foundation and CDC's Project PrIDE (PrEP, Implementation, Data2Care, Evaluation). LINCS Team members are directly paired with newly identified HIV-positive individuals and remain paired in a supportive relationship for up to **three months** following initial HIV diagnosis. The program ensures that: 1) linkage to care is made **within 30 days** for **everyone** testing positive in San Francisco; and 2) **all** newly-diagnosed individuals are offered comprehensive and immediate linkage and partner services.

In 2014, through the LINCS program, **84%** of newly diagnosed patients were linked to care within 1 month and **75% were virally suppressed within 12 months of diagnosis**. By comparison, among all people living with HIV in SF, the overall viral suppression rate is **72%**. By expanding LINCS navigation capacity, we are hoping to improve this rate. In the first 9 months of expanding LINCS navigation capacity, the program received a total of **321** referrals; located and enrolled **120** patients into navigation; re-linked **108 (90%)** of these patients to care; and increased viral suppression among this population from **11% to 50%**. **One-third** of clients re-linked to care are **homeless** and nearly **half** are substance-using. These data suggest that the LINCS navigation efforts are highly effective and should be sustained beyond the grant-funded period in order to sustain improvements in viral suppression city-wide.

#### **C.1.b) Planned Activities of the San Francisco EMA EIIHA Plan for FY 2017**

##### **C.1.b.1) Primary Activities to be Undertaken, Including Systems-Level Interventions:**

The FY 2017 EIIHA Plan will encompass **three** broad activity areas which mirror those of the three succeeding EIIHA plans. The first area involves continuing to identify individuals who are unaware of their HIV status. Most MSM will be provided with high-quality rapid testing and acute RNA pooled screening. San Francisco is using rapid 4<sup>th</sup> generation combination antibody / antigen (Ab/Ag) tests at sites that do not currently have access to pooled RNA testing. The 4<sup>th</sup> generation rapid testing identifies not only HIV antibodies but also HIV-1 p24 antigens, which allows for early identification and rapid treatment of acute HIV infection. All other existing rapid HIV screening technologies have window periods exceeding the acute infection period, which may result in false negative tests in acutely-infected patients, and in turn lead not only to missed HIV diagnoses but to lost opportunities to intervene with treatment and counseling at the time when an individual is at greatest risk to pass their HIV infection on to others. Additionally, the 4<sup>th</sup> generation HIV Ab/Ag combination tests provide result in 20 minutes.

The second key activity area involves ensuring that HIV-positive individuals are successfully linked to essential medical and social services based on individual need. Specific activities to be undertaken through the Plan will be tailored to meet the needs of



its three identified target population groups, with a particular emphasis on continuing to implement the city-wide LINCS program (newly identified as well as re-link individuals out of care).

A third key activity aims to promote and facilitate ever-widening utilization of PrEP throughout the EMA, and in particular, to address disparities in PrEP uptake. DPH is leveraging multiple funding sources to implement a multi-pronged approach that includes: 1) community, clinic, and pharmacy-based PrEP programs; 2) training of HIV test counselors to provide a gateway to PrEP; 3) social marketing; and 4) public health detailing.

**C.1.b.2) Major Collaborations with Other Programs and Agencies, Including HIV Prevention and Surveillance Programs:** HIV Health Services works in close partnership with the three Branches in the Population Health Division - Community Health Equity & Promotion (CHEP), Disease Prevention & Control (DPC), and Applied Research, Community Health Epidemiology & Surveillance (ARCHES) Branches to plan services, design interventions, and share data and emerging findings. CHEP oversees community-based prevention and testing services; DPC oversees the LINCS program and operates City Clinic (the municipal STD clinic which offers HIV testing, PrEP, and HIV early care); and ARCHES maintains the SF spectrum of engagement data as well as facilitating data to care and data to PrEP strategies. In addition, the DPH Primary Care Division is a close partner, providing routine HIV testing, care to people living with HIV, and PrEP access and navigation services.

Through a strong working relationship, these three partner entities are able to closely coordinate prevention and care planning and interventions with the goal of maximizing available resources and ensuring a seamless testing system in the EMA. The collaboration also aims to ensure non-duplication and non-supplantation of Ryan White Program funding. The collaboration is augmented by strong working relationships involving virtually all providers of HIV-specific prevention and care services in the EMA, as well as agencies serving high-prevalence populations at risk for HIV infection.

The EIIHA Plan is supported by two additional key collaborators – 1) the **HIV Community Planning Council (HCPC)**, our region’s newly merged HIV prevention and care community planning group, which includes HIV prevention and care service providers from all three counties as well as prevention and care consumers, and 2) the **Getting to Zero (G2Z) Consortium**, a multi-sector independent consortium of public and private sector agencies, service providers, consumers, and planners operating under the principles of **collective impact**. Modeled after the UNAIDS goals, the consortium aims to achieve zero new infections, zero HIV-related deaths, and zero stigma. This “getting to zero” vision has become the guiding framework for SF City as a whole. In this spirit, the HCPC and the G2Z coalition work with DPH to establish and implement priorities to improve outcomes along the HIV prevention, care, and treatment continuum.

Although not required by HRSA, in San Francisco, the HCPC coordinates Part B services in conjunction with Part A services to maximize the impact of these two funding streams. This service planning process is in turn coordinated with all relevant County units, including the Community Health Equity and Promotion and the Disease Prevention and Control Branches, in order to enhance regional efforts to identify and link to care persons with HIV who are unaware of their positive status. At the same time, representatives of agencies receiving funds through Ryan White Parts C, D, and F play an active role on the

Planning Council to ensure integration and coordination of EIIHA activities with other Ryan White-funded services.

**C.1.b.3) Anticipated Outcomes of the Overall EIIHA Strategy:** The FY 2017 San Francisco EMA EIIHA Plan has three primary goals: **1)** to increase the percentage of individuals in Marin, San Francisco, and San Mateo counties who are aware of their HIV status; **2)** to increase the percent of HIV-positive individuals in our region who are effectively engaged in HIV care; and **3)** to reduce disparities in PrEP uptake, HIV infection, HIV testing, and successful and sustained linkage to care. SF EMA's EIIHA plan also includes approaches designed to reach the specific communities and individuals who are most vulnerable to HIV infection **before** they become infected. If G2Z is successful, the need for an early intervention plan should greatly diminish, because new infections will be virtually eliminated.

**Specific anticipated outcomes of the local EIIHA strategy are codified as objectives in the new 2017-2021 Integrated HIV Prevention and Care Plan developed for the San Francisco region.** Each objective corresponds to a specific objective of the National HIV/AIDS Strategy, and represent aggressive approaches to achieving rapid enhancements along the entire HIV care continuum, including the following:

- **Objective # 1.1:** By December 31, 2021, increase the percentage of people living with HIV who know their serostatus to at least **96%**;
- **Objective # 1.2:** By December 31, 2021, reduce the number of annual new HIV diagnoses by at least **50%**;
- **Objective # 1.3:** By December 31, 2021, increase the utilization of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) among high-risk HIV-negative persons by at least **50%**; and
- **Objective # 2.1:** By December 31, 2021, increase the percentage of annual newly diagnosed persons linked to HIV medical care within one month of HIV diagnosis to at least **90%**.

The FY 2017 San Francisco EIIHA plan will reach many individuals who are disconnected from the system in order to bring them into HIV prevention, testing, linkage, and care services. Routine HIV testing, targeted community outreach, expanded case management services, and PrEP services specific to underserved communities will help to reduce disparities among group such as MSM of color, substance users, African American women, uninsured and economically impoverished populations, homeless persons, and young MSM – all populations that have experienced historical HIV access and treatment disparities along with high rates of late HIV testing. The San Francisco EMA will utilize its EIIHA plan and matrix to focus on increasing awareness of HIV status and promoting treatment utilization among underserved populations as a way to continue to address HIV-related health disparities.

**C.1.c) How the Proposed FY 2017 EIIHA Plan Contributes to the Goals of the NHAS 2020:** The goals and objectives of the proposed FY 2017 EIIHA Plan continue to be fully consistent with and contribute to the goals of the White House Office of AIDS Policy's National HIV/AIDS Strategy, including the Strategy's three primary goals of: 1) reducing new HIV infections, 2) increasing access to care and improving health outcomes for people living with HIV, and 3) reducing HIV-related disparities and health inequities.<sup>14</sup> The local EIIHA strategy is also fully consistent with HRSA's goal of making unaware individuals

aware of their HIV status, particularly in terms of the strategy's aggressive approach to reaching and testing highly impacted HIV populations in the San Francisco EMA.

**C.1.c.1) How the Proposed FY 2017 EIIHA Plan Contributes to Improving Health Outcomes Along the HIV Continuum:**

The SF EMA aims to achieve an HIV prevention and care continuum in which no one is at risk for HIV, and everyone who is living with HIV knows their status, is linked to and retained in care, and is virally suppressed. The EIIHA Plan contributes to improving health outcomes in the following ways:

- Reducing **at risk** and **HIV-infected** populations by improving awareness and uptake of PrEP, with a particular focus on African American and Latino MSM, young MSM, and trans women.
- Increasing awareness of HIV status through increasing access to routine HIV testing and community-based rapid testing to detect acute infections. DPH continues to promote frequent testing (every 3 to 6 months for the three high prevalence populations - MSM, PWID, and transwomen) and test counselors are trained to deliver this messaging during testing encounters. It is worth noting that the city of San Francisco has the highest rates of HIV status awareness in the nation with only **6.5%** not aware of their infection, and with a sero-unaware rate of only **3%** among MSM.
- Improving **linkage and retention** rates through continued implementation of the LINCS program as well as expanded case management services
- Increasing **viral suppression** as a direct result of improvements along the rest of the continuum

**C.1.c.2) Innovative Approaches Used in the EIIHA Plan to Address Barriers to HIV Testing and Treatment and Improve Outcomes along the HIV Care Continuum:**

San Francisco has vigorously embraced **pre-exposure prophylaxis (PrEP)** as an effective approach to reducing new infections among high-risk individuals in the EMA. San Francisco has become known as the premier hub of PrEP use worldwide, with San Francisco chosen as one of two US sites for the global iPrEx study of once-daily Truvada use for gay men, and with the city establishing the nation's first PrEP demonstration project, which has since evolved into an ongoing program.<sup>15</sup> The following is an overview of San Francisco's PrEP strategy:

**1) Community, Clinic, and Pharmacy-Based PrEP Programs:**

- By March 31, 2017, ensure that **7** community-based PrEP community engagement and navigation programs in place, four of which will focus on particular populations with disparities in PrEP awareness, access, and uptake: African American MSM, Latino MSM, young MSM, and trans women. (Three programs are supported by funds prioritized by Supervisor Campos; four are supported by SF city funds raised by the G2Z consortium supplemented by funding from the CDC PRIDE grant).
- Expand the well-established San Francisco City Clinic PrEP delivery program including, exploring ways to use rectal STI data to craft and pilot a "data to PrEP" model, modeled after "data to care" efforts.
- Ensure training by the San Francisco Health Network to prescribe and administer PrEP at the Network's **14** neighborhood clinics and through the Ward 86 HIV Clinic at Zuckerberg San Francisco General (ZSFG) hospital. This includes a novel PrEP tele-medicine program designed to promote medication adherence and regular follow-up HIV/STI testing using a panel management approach.

- Test an innovative pharmacy-based PrEP access model that does **not require a doctor's visit**, providing Truvada to youth who are ineligible for insurance or who are on their parents' insurance and are concerned about disclosure.
- 2) Training of HIV/HCV Test Counselors to Provide a Gateway to PrEP:**
- Ensure that San Francisco's model 4-day HIV/HCV certification program now includes a PrEP module. The goal of this module is to develop skills needed to help clients determine if PrEP is right for them and if so, how to access it. Among other outcomes, this training has already greatly supported consistent messaging to high-risk groups to provide assurance that PrEP is safe and accessible.
- 3) Social Marketing:**
- Continue to implement the SFDPH "Our Sexual Revolution" campaign designed to raise awareness of PrEP among MSM of color and transwomen. (<http://oursexualrevolution.org/>).
- 4) Public Health Detailing:**
- Deploy PrEP experts to conduct public health detailing with doctors throughout the City to support clinicians to expand their competency in prescribing PrEP and conducting appropriate assessment and follow-up.

San Francisco has also introduced the highly influential and impactful **Rapid Antiretroviral Program Initiative for New Diagnosis (RAPID)**, a program that began at Zuckerberg San Francisco General Hospital 2 years ago and has expanded to HIV clinics city-wide. RAPID is a comprehensive initiative designed to help clients overcome the financial and social barriers to undergoing testing for HIV and being linked to care.<sup>16</sup> RAPID seeks to reduce the time between diagnosis, linkage to a primary care provider, antiretroviral initiation, and viral suppression. Through RAPID, five-day "treatment packs" are dispensed to new clients entering the clinic on the **same day** they have received an HIV diagnosis and a full set of labs are drawn and the patient meets with a social worker to ensure coverage for the continuance of the ART medications. RAPID not only promotes patient health through early engagement in treatment, but plays a significant role in preventing new infections by reducing infectivity when patients are experiencing acute HIV syndrome, during which they are at greatest risk to pass the virus on to others. The RAPID program is able to provide immediate medication linkage for clients linked at HIV testing sites throughout San Francisco, and has been extremely effective in helping the city meet its long term test and treat goals.

**C.1.c.3) Collaborations Being Pursued Within the Community and Other Public Stakeholders to Strengthen Outcomes Along the HIV Care Continuum:** Key

collaborations include those highlighted in section C.1.b.2, especially the active partnerships within SFDPH, across the three regions that make up the San Francisco EMA, and with the HIV Community Planning Council and G2Z consortium. Ultimately, the collaborations with the direct service providers – particularly those that are focusing heavily on the most disproportionately impacted communities – that will help the EMA improve its outcomes along the continuum. DPH actively collaborates with the HIV/AIDS Providers Network, and helps facilitate several key cross-provider efforts including the HIV Testing Coordinators Network, the PrEP Navigators Network, and the HIV Frontline Workers Group.

**C.1.c.4) How EIIHA Data is Used to Analyze or Address Gaps in the HIV Care Continuum:**

- **HIV and STI Surveillance Data:** The San Francisco EMA uses a data to care model to identify individuals and populations who are not linked to HIV care or who are at risk of falling out of care and, who might not otherwise be “on the radar” of clinical and social services providers and thus would not have been referred to LINCOS for follow up. The objective is to permanently link or re-link these individuals to comprehensive HIV services. In addition, DPH is exploring whether rectal STD infection data could be used as a marker to identify individuals at high risk for HIV who could then be educated about and linked to PrEP services (“data to PrEP”).
- **Community-Based HIV Testing Data:** Four questions are now included on the community-based HIV testing form that allow DPH to assess where the gaps are in knowledge, awareness, and uptake of PrEP. These data have informed the prioritization of PrEP services for MSM of color, young MSM, and trans women.

**C.1.d) How the Unmet Need Estimate Based on the HIV Care Continuum and Activities Related to the Unmet Need Population Inform and Relate to EIIHA Activities:**

The FY 2017 EIIHA Plan responds to the EMA’s annual unmet need process both prospectively and retrospectively. In a prospective sense, the EIIHA Plan seeks to **continue to decrease the number of persons living with HIV/AIDS in the region who are unaware of their HIV status**. Through our highly successful, multi-partner based G2Z initiative, the EMA has already achieved unprecedented success in reaching a region-wide HIV unaware percentage of only **6.4%** - a percentage that already far exceeds the national HIV Continuum Initiative goal of at least **10%** unaware. However, as the EMA achieves greater success, it also becomes increasingly difficult to identify undiagnosed infected individuals, requiring new and innovative approaches to seek out the small remaining pockets of undiagnosed infection. Retrospectively, the EIIHA Plan utilizes **unmet needs data** to prioritize specific target populations on which to focus regional outreach, testing, and care linkage and retention activities and resources.

**C.1.e) How the FY 2016 EIIHA Plan Influenced the Development of the FY 2017 EIIHA Plan:**

A key facet of the EMA EIIHA plan is that it is **highly flexible** in order to incorporate new prevention advances and community input and engagement in real time. In addition, HIV testing and linkage models identified in the 2016 Plan have proved successful in reducing undiagnosed infection and improving linkage to care, so these models will continue. The EMA will continue to develop and implement out partnership-based interventions that enhance early intervention, including the expanded use of pre-exposure prophylaxis (PrEP), rapid linkage to care, and widespread use of rapid 4<sup>th</sup> generation rapid antigen /antibody testing.

**C.1.f) Any Planned Efforts to Remove Legal Barriers, Including State Laws and Regulations, to Routine HIV Testing:**

California law requires that every patient who has blood drawn at a primary care clinic, as defined, and who has consented to the test to be offered an HIV test that is consistent with the United States Preventive Services Task Force recommendations for screening for HIV infection. A new bill passed this September created a pilot project, administered by the State Department of Public Health, to assess and make recommendations regarding the effectiveness of the routine offering of an HIV test in the emergency department of a hospital.

**C.1.g) The Three FY 2017 EIIHA Target Populations:** To define and focus EIIHA activities, the following **three** populations will continue to serve as the key target groups for the FY 2017 San Francisco EMA EIIHA Plan:

1. Males Who Have Sex with Males (MSM)
2. People Who Inject Drugs (PWID)
3. Transgender Females Who Have Sex with Males (TGF/M)

**C.1.g.1) How and Why Target Populations Were Selected:** The San Francisco EMA's FY 2017 EIIHA target populations have been selected on the basis of **three** key factors. **First**, from an epidemiological standpoint, these three populations together encompass nearly **95%** of all persons currently living with HIV/AIDS in the San Francisco EMA. MSM alone – including MSM who inject drugs – make up **85.4%** of all persons living with HIV/AIDS cases in the region as of December 31, 2015, while non-MSM PWID make up another **6.3%** of all local PLWHA. **Second**, the populations represent the three groups most highly prioritized in the EMA's 2017-2021 Integrated HIV Prevention and Care Plan, which represents the product of intense study and collaborative planning. And **third**, the selected populations contain the highest rates of new HIV diagnoses as reported through HIV testing data for the period January 1 - June 30, 2015.

**C.1.g.2) Specific Challenges or Opportunities in Working with the Target Populations:**

Perhaps the greatest challenge as the region approaches zero new HIV infections and 100% viral suppression is the continued prevalence of disparities along the continuum of care. While strategies implemented to date have benefited white gay men, other populations have not seen the same degree of benefit. For this reason, the new 2017-2021 Integrated HIV Prevention and Care Plan embraces a health equity approach to HIV prevention, care, and treatment as its focus going forward. The Plan includes numerous potential strategies to be considered by the merged Planning Council in addressing disparities, including:

- Implement a pilot mentoring program for young gay men and transfemales that supports the development and maintenance of personal strategies for supporting sexual health.
- Develop and implement a standard HIV curriculum for substance use and mental health providers, including culturally competent approaches for screening for HIV risk and referral and linkage resources.
- Develop and disseminate PrEP Standards of Care through the San Francisco Department of Public Health, including standards on administering, tracking, and managing PrEP
- Implement DPH transgender-specific sex and gender guidelines that adhere to specific data collection principles including the following: 1) Naming should be self-identified; 2) Transgender and sexual orientation data should be coded with caution and care when working with minors in consideration of the fact that health data are legally accessible by guardians; 3) information should be up-to-date; 4) Naming should allow for both consistency and relevance and compliance and comparability.
- Explore the creation of new program approaches to reduce HIV and hepatitis C infection among persons who inject drugs, including approaches that incorporate a harm reduction perspective.

- Develop and implement new models for integrating geriatric specialists into the HIV clinic setting.
- Recognize the growing shortage of physicians who are skilled in both HIV and geriatric care and advocate for the recruitment and training of specialists in these dual areas to address growing older HIV populations.
- Create a new level of specialized training and certification to create case management staff who are expert in the distinct system of services that exists for persons 50 and older.

**C.1.g.3) Specific Activities to be Utilized Within the Target Populations:** The San Francisco EMA will employ a broad range of strategies to expand awareness of, access to, and utilization of HIV testing and care services in the service region for persons who are currently unaware of their HIV status and for persons with HIV who have dropped out of or become lost to care. The table beginning on the following page outlines these activities in relation to the three FY 2017 target populations. All activities listed in the EIIHA Plan will be coordinated with activities conducted by the HIV prevention units in the three EMA counties as outlined in the integrated jurisdictional HIV Prevention Plans. All activities will also be coordinated to promote HIV prevention and care integration in the region.

In addition to the activities listed on the chart below, San Francisco will also continue implementation of care access enhancement activities being made possible through the California Center for Medicaid and CHIP Services **Delivery System Reform Incentive Pool (DSRIP)** and its **Category V** program. This program was specifically designed to enhance the capacity of participating hospitals to develop programs to provide access to high-quality, coordinated, integrated care to patients diagnosed with HIV, particularly Low Income Health program (LIHP) enrollees who previously received services through Ryan White funding. The San Francisco DSRIP Category V program is being implemented at Zuckerberg San Francisco General Hospital and is creating a range of specific HIV care enhancements, many of which are expected to expand the quality of care linkage and retention services in the region. This includes creation of a **model retention program** within patient-centered medical homes for persons with HIV, which began in April 2013 with a pilot program at San Francisco General Hospital for patients with high rates of missed primary care appointments as part of the ongoing PHAST program.

**C.1.g.4) SMART Objectives for Each EIIHA Plan Component:**

**1. MSM:**

1. Between March 1, 2017 and February 28, 2018, to provide a total of at least **19,000** documented HIV antibody tests for MSM in the San Francisco EMA.
2. Between March 1, 2017 and February 28, 2018, to identify a total of at least **200** new or previously diagnosed HIV-positive individuals within this population.
3. Between March 1, 2017 and February 28, 2018, to ensure that at least **95%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.
4. Between March 1, 2017 and February 28, 2018, ensure that at least **93%** of newly identified HIV-positive individuals have a confirmed linkage to care services.
5. Between March 1, 2017 and February 28, 2018, ensure that at least **95%** of newly identified HIV-positive individuals are referred to HIV prevention services; and
6. Between March 1, 2017 and February 28, 2018, ensure that at least **75%** accept partner services.

▪ **PWID:**

7. Between March 1, 2017 and February 28, 2018, to provide a total of at least **1,750** documented HIV antibody tests for PWID in the San Francisco EMA.
  8. Between March 1, 2017 and February 28, 2018, to identify a total of at least **35** new or previously diagnosed HIV-positive individuals within this population.
  9. Between March 1, 2017 and February 28, 2018, to ensure that at least **90%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.
  10. Between March 1, 2017 and February 28, 2018, ensure that at least **82%** of newly identified HIV-positive individuals have a confirmed linkage to care services.
  11. Between March 1, 2017 and February 28, 2018, ensure that at least **92%** of newly identified HIV-positive individuals are referred to HIV prevention services; and
  12. Between March 1, 2017 and February 28, 2018, ensure that at least **75%** accept partner services.
- **Transgender Women Who Have Sex with Men:**
13. Between March 1, 2017 and February 28, 2018, to provide a total of at least **480** documented HIV antibody tests for transgender women who have sex with men in the San Francisco EMA.
  14. Between March 1, 2017 and February 28, 2018, to identify a total of at least **11** new or previously diagnosed HIV-positive individuals within this population.
  15. Between March 1, 2017 and February 28, 2018, to ensure that at least **90%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.
  16. Between March 1, 2017 and February 28, 2018, ensure that at least **82%** of newly identified HIV-positive individuals have a confirmed linkage to care services.
  17. Between March 1, 2017 and February 28, 2018, ensure that at least **92%** of newly identified HIV-positive individuals are referred to HIV prevention services; and
  18. Between March 1, 2017 and February 28, 2018, ensure that at least **75%** accept partner services.

**C.1.g.5) Responsible Parties, Including Coordination with Other Agencies and Programs and Respective Roles:** Implementation and evaluation of the FY 2017 EIIHA Plan will be the joint responsibility of SFDPH HIV Health Services, Community Health Equity & Promotion Branch, the Disease Prevention and Control Branch, and the ARCHES Branch, with the close collaboration of the San Francisco HIV Community Planning Council and prevention and care staff in Marin and San Mateo Counties. County staff will continually collect data related to HIV testing, service linkage, and other follow-up activities for each of the target populations, will regularly report this information to the State of California, and will summarize the data in regular reports to HRSA as required.

**C.1.g.6) Planned Outcomes to be Achieved for the Target Populations as the Result of EIIHA Plan Activities:** The proposed FY 2017 EIIHA strategy will continue the work of the San Francisco EMA to expand and enhance awareness and utilization of HIV testing throughout the region for the project's three key populations, while increasing utilization of care and prevention services and promoting greater adherence to HIV treatment services.

**C.1.h) How EIIHA Data Are Utilized in Planning for Services in the Jurisdiction:** At the level of local prevention impacts, the San Francisco EMA utilizes National HIV Behavioral Surveillance (NHBS) data to assess gaps in HIV testing and PrEP uptake in order to prioritize expanded and enhanced HIV testing and PrEP outreach services for specific underserved communities. Our region also conducts at least semiannual reviews of HIV



testing data to assess gaps in testing access and assess gaps in PrEP knowledge and use among those accessing HIV testing, in order to prioritizing testing and PrEP outreach for specific communities. The EMA also regularly reviews surveillance data on HIV care linkage rates to identify disparities and to develop and implement programs to address them. Meanwhile, the newly merged San Francisco HIV Planning Council regularly considers EIIHA data in assessing gaps and prioritizing services and allocations.

**C.1.i) How Efforts to Impact the EIIHA Population Are Evaluated in the Jurisdiction:**

The San Francisco EMA employs several approaches to evaluate impacts on the EIIHA population throughout the jurisdiction. The San Francisco Department of Public Health reviews the HIV Care Continuum annually as an evaluation of the citywide impact of EIIHA efforts. At the same time, Department and community-based prevention, PrEP, testing, and linkage programs have required metrics to track performance. If it is found that programs are not meeting targets, DPH staff is available to provide technical assistance. The most significant measures for evaluating the effectiveness of the EIIHA strategy are: a) a decline in new HIV infections; b) an increase in early HIV diagnoses; c) a decrease in the time needed to link persons to care; and d) time to viral load suppression decreasing. These can all be measured directly or indirectly through surveillance data.

**C.1.j) How Information Related to Planning and Evaluation of EIIHA Data Are**

**Disseminated in the Jurisdiction:** As a document that is jointly developed by HIV Health Services, the Community Health Equity & Promotion Branch, and the Disease Prevention & Control Branch, the FY 2017 EIIHA Plan will be shared with the San Francisco EMA HIV Community Planning Council in order to facilitate integrated planning. The EIIHA Plan will also be shared with prevention staff of both Marin and San Mateo counties. Ongoing progress related to EIIHA action steps will be extensively reported to the Planning Council with the goal of refining and helping shape future EIIHA action plans and strategies. Model interventions and programs developed through the EIIHA program will be broadly disseminated and shared among public and private providers throughout the San Francisco EMA, including through trainings developed and presented to community-based HIV providers and public and private medical providers. The San Francisco EMA may also publish best practice documents or guidelines related to specific aspects of the outreach, testing, and linkage enhancement initiative, and/or develop and conduct trainings for local agencies and staff on demonstrated methods for enhanced EIIHA-related planning and program implementation.

**C.2) UNMET NEED**

**Unmet Need Frameworks - See Tables in Attachment 4**

**Current Methodology:**

**C.2.a.1) Current and New Unmet Need Methodologies:** The California Department of Public Health, Office of AIDS provided an analytical dataset which included persons initially diagnosed with HIV through December 31, 2015 and living in the San Francisco EMA at the end of 2015. The dataset contained variables allowing us to calculate unmet need using either the current HRSA methodology or the new methodology based on the HIV care continuum. The **current HRSA methodology** includes all persons living in the EMA who were diagnosed through the end of 2015, and classifies persons who had a qualifying HIV laboratory test (CD4, viral load, or genotype) or received ART during 2015 as having met need for care. This methodology encompasses both HIV surveillance laboratory test data and care information from ADAP (AIDS Drug Assistance Program) and ARIES (AIDS

Regional Information and Evaluation System). In contrast, the **new HIV continuum methodology** utilizes only HIV surveillance data and includes persons living in the EMA in 2015 who were diagnosed with HIV prior to 2015. The new methodology calculates an “in care” metric which indicates whether a person had at least one CD4 count, viral load, or genotype test during 2015, as well as a “retained in care” metric indicating whether a person had 2 or more such tests at least 3 months apart during 2015. The retained in care metric is considered equivalent to met need under the new methodology.

**C.2.a.2.a) Demographics of Unmet Need Populations:** The chart on the following page describes demographic information on PLWH with unmet need for the period January 1 - December 31, 2015 (see **Figure 11**). The table provides population estimates across **four** critical categories: ethnicity, gender, age group, and transmission category. While San Francisco has pioneered several new approaches to mapping HIV-infected PLWHA in the city using zip codes and census tracts as a way to help target HIV testing outreach and prevention efforts, these methods are unreliable in terms of predicting place of residence for persons who are either out of care or unaware of their HIV status, in part because of the transience of persons with HIV in San Francisco and in part because of the extensive in-migration of persons with HIV who travel to the EMA seeking care. As shown in the table, while unmet need populations are distributed roughly evenly in proportion to their numbers in the total unmet need population, **Latinos (22%)** have the highest proportion of unmet need among all ethnic groups, while persons **30-49 years of age (21%)** have the highest proportion of unmet need among age groups. **Heterosexual adults (22%** and **persons who inject drugs (PWID) (21%)** have the largest proportion of unmet need among all transmission categories.

**C.2.a.2.b) Unmet Need Trends Over Time:** The charts below provide 4-year unmet need trend data using both the current **and** new continuum-based methodology (see **Figure 12** and **Figure 13**). The region experienced a major shift in case reporting methodology beginning in the 2012 fiscal year which makes FY 2011 data not comparable. The region continues to experience a situation in which roughly 1 in 5 persons living with HIV in the region are not accessing HIV care in a consistent and reliable manner - a situation the EMA continues to aggressively address in regard to both planning and service delivery.

**Figure 12. Unmet Need Percentages in the San Francisco EMA 2012 - 2015 Using Current Methodology**

Proportion of Unmet Need in San Francisco EMA - 2012 - 2015			
CY 2012	CY 2013	CY 2014	CY 2015
25%	25%	20%	18%

Figure 11. San Francisco EMA Demographic Analysis of People in and Out of Care\*  
January 1, 2015 through December 31, 2015: Persons Living with HIV (PLWH)

Characteristic	#1: PLWH Population	#2: Number with Met Need	#3: Number with Unmet Need	#4: % of Unmet Need Population**	#5: % of Category with Unmet Need**	#6: % of Total PLWH Population**
All PLWH	16,554	13,517	3,037	100%	18%	100%
<b>Race/Ethnicity:</b>						
African American	2,167	1,771	396	13%	18%	13%
Latino	3,424	2,675	749	25%	22%	21%
Asian/PI	1,055	845	210	7%	20%	6%
White	9,404	7,783	1,621	53%	17%	57%
Other/Unknown	504	443	61	2%	12%	3%
<b>Gender</b>						
Female	1,095	897	198	7%	18%	7%
Male	15,058	12,277	2,781	92%	18%	91%
Transgender	401	343	58	2%	14%	2%
<b>Age in Years***:</b>						
0-24	176	149	27	1%	15%	1%
25-29	575	469	106	3%	18%	3%
30-49	6,351	5,045	1,306	43%	21%	38%
50-64	7,748	6,423	1,325	44%	17%	47%
65 or older	1,704	1,431	273	9%	16%	10%
<b>Transmission</b>						
MSM	11,865	9,772	2,093	69%	18%	72%
IDU	1,106	871	235	8%	21%	7%
MSM IDU	2,275	1,890	385	13%	17%	14%
Heterosexual	1,044	812	232	8%	22%	6%
Other/NIR Adult	224	141	83	3%	37%	1%
Pediatric	40	31	9	0%	23%	0%

\* Using the current HRSA Unmet Need Framework.

\*\* Column calculations: Column #4 = Column #3 / Total with Unmet Need (n=3,037); Column #5 = Column #3 / Column #1; Column #6 = Column #1 / Total PLWH (n=16,554).

\*\*\* Age as of 12/31/2015.